AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION FOR MEDICAL NUTRITION THERAPY BY VERBAL AND/OR WRITTEN COMMUNICATION

I hereby authorize ***Patricia A. Ford, DrPH, MPH, RD***
to disclose information pertinent to my treatment status, diagnosis, nutrition status, to the following person(s) and/or organization(s).

1) Therapist ____
Address ____
Phone ____

2) Primary care MD ____
Address ____
Phone____

3) Parents or guardians____
Address ____
Phone ____

4) Other ____
Address ____
Phone ____

Patient Name ____
Date of Birth ____
SS#____________________ Phone# ____________________

______________________ ______________ ____________
Signature of Patient or Legal Representative (Relationship to Patient) Date

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